STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
<u></u>		15G190	B. WIN			03/30/	2012
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC. THE			ENUE C TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	TT1, IIV +0010		(V5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
W0000							
			W0	000			
This visit was for the investigation of							
Complaint #IN00104522.							
	COMPLAINT #						
		TED, Federal and state					
		ted to the allegation are					
	· ·	V104, W111, W122,					
	W149, W153, W192, W318, W331,						
	W340, W368, ar	nd 9999.					
	Dates of survey: and 30, 2012	March 22, 26, 27, 28, 29					
		000500					
	Facility number:						
	Provider number						
	AIM number: 10	00234570					
	1	tine Colon, Medical IRP- Team Leader					
	The following 1	oficiancias also roflect					
	1	eficiencies also reflect					
	state findings in 9.	accordance with 460 IAC					
) J.						
	'	completed on 4/9/12 by					
	i iiii Shebei, Me	dical Surveyor III.					
1	I		I		I		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000722

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190		(X2) MI A. BUII B. WIN	LDING	00	(X3) DATE (COMPL 03/30/	ETED	
	PROVIDER OR SUPPLIER			120 AV	ADDRESS, CITY, STATE, ZIP CODE ENUE C TH, IN 46319		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview for		W0	102	See W 104 page 3, W 111 page 14, W 122 page 16	ge	04/29/2012
	1 of 1 discharged facility failed to Participation: Go governing body to operating direction ensure the facility policy and proces	I clients (client A), the meet the Condition of overning Body. The failed to exercise on over the facility to y implemented their dures to prevent neglect o ensure the health needs					
	Findings include	:					
	 Please refer to W104. The governing body failed, for 1 of 1 discharged clients (client A), to implement the facility's policy and procedure to prevent neglect by failing to ensure the facility met the needs of the client, and ensured a client's health needs were not neglected. Please refer to W111. The governing body failed, for 1 of 1 discharged client (client A), to ensure all pertinent information in regard to the client's health were part of the client's chart/records. 						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G190		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	ie survey ipleted 30/2012	
	PROVIDER OR SUPPLIER		120 AV	ADDRESS, CITY, STATE, ZIP 'ENUE C TH, IN 46319	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	body failed to ex operating direction regards to meeting Participation: Clifacility neglected neglect policy and timely health car client (client A).	o W122. The governing ercise general policy and on over the facility in ag the Condition of ient Protections. The I to implement their id neglected to provide e, for 1 of 1 discharged relates to complaint				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		15G190		LDING		03/30/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
ADC 05 (NODTHWEST IND	IANIA INIC. THE			ENUE C		
ARC OF I	NORTHWEST IND	IANA INC, THE		GRIFFI	TH, IN 46319		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0104	483.410(a)(1) GOVERNING BO	ODY ody must exercise general					
		nd operating direction over					
	•		W0	104	The IDT team will meet to revi	ew	04/29/2012
					current risk plans and discuss	any	
					additional needs that may requ		
	Based on record	review and interview for			risk plans. If additional risk pla	ns	
	1 of 1 discharged	d client (client A), the			are needed, they will be		
	governing body	* * * * * * * * * * * * * * * * * * * *			implemented and staff will be trained on the plans. To ensu	ıro	
					future compliance, risk plans v		
	operating direction over the facility to ensure implementation of its policy and				be discussed and new plans, i		
	•				necessary will be developed		
		vent neglect and to			during clients annual meetings	S.	
	provide for the c	lient's health needs.			Community Services nurse wi	II	
					train staff on when to call 911		
	Findings include	:			when to call a nurse/and will to all staff before they work with		
	A request for the	facility's internal			clients. To ensure future compliance, Community Servi	CAS	
	incident and acci	-			Nurse and or Service Coordinate		
		ords was made on			will access each situation as		
	•	P.M No internal			needed to determine and furth	er	
					instruct staff to contact 911 an	d	
		t reports and investigation			follow proper procedures.		
	records were sub	mitted by the facility for			Community Services Nurse wi		
	review.				be trained on assessing client		
					within 24 hours of a change in condition. To ensure future		
	A review of clien	nt A's record was			compliance, Community Servi	ces	
	conducted on 3/2	22/12 at 2:55 P.M			Nurses will be monitored by th		
	Review of client	A's medical record			Director of Health and Safety		
	indicated:				Services weekly for three mon	iths	
	maiouiou.				and monthly thereafter.		
	NI	4-4-4-1/0/12: UD: 1			Community Services Nurses v	vill	
	_	dated 1/9/12: "Received			be trained to utilize MITC for		
		phome (sic) staff Saturday			significant changes in care, preventing staff from beginning	α.	
		nt A] was coming down			their shift without being inform	•	
	the steps and sat	down and passed out.			of change. To ensure future	cu	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190		(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE S COMPL 03/30/	ETED	
	PROVIDER OR SUPPLIER		ST 12	20 AVE	DDRESS, CITY, STATE, ZIP CODE ENUE C TH, IN 46319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	III PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	Came to about 4: of person, place a 3/11 with syncop this appeared to b just to continue t [client A] when p failed to indicate the client's diagn review failed to it assessment or a w Nursing notation a call from staff of that [client A] was stand at all. She bowels and black even realize it. I to have her trans (Emergency Roo (treatment). Adr UTI (Urinary Tra clot in left leg." Nursing notation "Discharged from Saturday 2/11/12 order for Couma (everyday)." Further review of client A was more home the day of	o seconds later was aware and time. Diagnosed be. Informed staff that be a syncope episode and o monitor and walk with possible." The record a "Health Risk Plan" for osis of syncope. Further indicate a nursing visit to the physician. dated 2/6/12: "Received for Sunday, 2/5/12 stating as very weak and couldn't also lost control of her der at the table and didn't (Nurse) instructed staff ported to the ER m) for evaluations and tx initted to hospital with act Infection) and blood dated 2/13/12:			compliance, Director of Health and Safety Services will contir to meet with Nurses daily and access new protocol for effectiveness.		DATE
	-	l down stairs. No					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		15G190	B. WIN			03/30/2012
NAME OF F	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP CODE ENUE C	
	NORTHWEST IND				TH, IN 46319	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1110		vas available for review		1.10		D.TTE
		cility's governing body				
	assured all group home staff were trained on client A's medical needs.					
	Nursing notation	dated 2/22/12:				
	"Received a call	from [Doctor's name]				
	office with a ver	bal order to hold				
	Coumadin for 3	days and have blood				
	drawn on 4th day	y due to high levels. Sent				
	memo to the house with instruction to					
	hold the medicat	ion and sent the lab order				
		lay when they have her				
	lab drawn."					
	An interview wi	th Direct Support				
	Professional (DS	SP) B was conducted on				
	3/29/12 at 4:45 I	P.M DSP B indicated				
	client A's Couma	adin was not held on				
	2/22/12 due to the	ne group home staff not				
	T -	emo from the nursing staff				
		2/27/12. DSP B further				
		I not receive any training				
	_	ent A's identified medical				
		at A was moved to the				
	group home on 2	2/11/12.				
	Nursing notation	dated 2/23/12:				
	"Received a call	from health tech stating				
	that [client A] ha	nd an episode at				
	workshop where	she was breathing hard				
	for a few second	s. Vitals were taken and				
	were WNL (with	nin normal limits). She				
	stated she seeme	ed normal now and that it				

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NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID PREFIX TAG Only lasted a few seconds. I instructed her to call if she did it again or if she had any odd behavior." No further documentation was available for review in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted concerns. Nursing notation dated 2/23/12: STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION) TAG ORDONAL TAG STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETION) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION) TAG ONLY ONL		AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190		A. BUILDING B. WING			COMPLETED 03/30/2012	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) only lasted a few seconds. I instructed her to call if she did it again or if she had any odd behavior." No further documentation was available for review in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted concerns. Nursing notation dated 2/23/12:	NAME OF PRO	OVIDER OR SUPPLIER		B. WIIV	STREET A			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Only lasted a few seconds. I instructed her to call if she did it again or if she had any odd behavior." No further documentation was available for review in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted concerns. Nursing notation dated 2/23/12:	ARC OF N	IORTHWEST INDI	ANA INC, THE		GRIFFI [*]	TH, IN 46319		
to call if she did it again or if she had any odd behavior." No further documentation was available for review in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted concerns. Nursing notation dated 2/23/12:	PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	COMPLETION
"Received a call from North (workshop) stating that there was a small bruise on [client A]'s head that they don't believe was there this morning." No further documentation was available for review in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted bruise. A request for the facility's internal incident/accident reports and investigation records was made on 3/26/12 10:30 A.M No reports or thorough investigation records were submitted by the facility for review. An interview with DSP C was conducted on 3/29/12 at 5:50 P.M DSP C indicated when she picked client A up from workshop on 2/23/12, client A was not acting herself, was not able to talk and seemed weak. DSP C stated she walked client A back into the day program to her assigned staff and asked what was wrong		only lasted a few to call if she did is odd behavior." New as available for indicate a nursing indicate the clien for an assessment. Nursing notation "Received a call stating that there [client A]'s head was there this modocumentation with the record to it assessment or to sent to a physicia the noted bruise. A request for the incident/accident records was made No reports or tho records were subtreview. An interview with on 3/29/12 at 5:55 when she picked workshop on 2/2 acting herself, was seemed weak. Declient A back into	seconds. I instructed her it again or if she had any No further documentation review in the record to g assessment or to t was sent to a physician t of the noted concerns. dated 2/23/12: from North (workshop) was a small bruise on that they don't believe orning." No further ras available for review andicate a nursing indicate the client was an for an assessment of facility's internal are ports and investigation to e on 3/26/12 10:30 A.M brough investigation mitted by the facility for th DSP C was conducted to P.M DSP C indicated client A up from 3/12, client A was not as not able to talk and SP C stated she walked to the day program to her					

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 30/2012
	<u> </u>		ADDRESS, CITY, STATE, ZIP (
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	120 AV	ENUE C TH, IN 46319		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	with her. The day program staff told DSP client A was not acting herself all day and client A would not eat her lunch which DSP C indicated was not normal for client A. DSP C then walked client A to the Health and Safety Tech to show her how client was acting and to show her a bruise she noticed on client A's head. DSP C indicated the Health and Safety Tech called the group home nurse and informed her of the injury and how client A was acting. DSP C indicated no directives were given by the group home nurse. DSP C then transported client A to the group home and dropped her off to her assigned staff. When asked if she documented this information on an incident report DSP C stated "No, because there was no significant injury." When asked if 911 was called she stated "No." Nursing notation dated 2/23/12: "Received call from group home staff stating that client was not acting herself. Client was able to answer questions when asked from staff. Instructed staff to take her v/s (vitals) and call me backStaff returned call v/s wnl (within normal limits), but client was not answering any questions and staff stated that client eyes were rapidly moving from side to side. I instructed staff to call 911. Client was transported to [Hospital name] for				

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		100100	B. WIN		PRESIDENCE OF THE CORP.	00/00/	2012
NAME OF F	PROVIDER OR SUPPLIER			120 AVE	DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	ANA INC, THE			гн, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	evaluation and tr	eatment."					
	An interview with on 3/29/12 at 4:2 indicated when coat the group home not acting herself. A could not talk wheelchair. DSI attempts were maken home nurse and sentither could be indicated DSP Be emergency nursicall nurse called they informed her not being able to her wheelchair. directed the staff and call her back taken and they red and a temperate home staff then coback and as they A's vitals, client the back of her home	ch DSP A was conducted as P.M DSP A client A was dropped off as at 4:15 P.M., she was f. DSP A indicated client and was slouched in her P.A. indicated three ade to contact the group Service Coordinator, but reached. DSP A then called the ang phone. When the on back around 6:00 P.M., or client A's condition of talk and her slouching in The on call nurse at 163/99 with a pulse of atture of 90.5. The group called the on call nurse were giving her client A's eyes began rolling in ead. DSP A indicated					
		on call nurse gave					
		911. DSP A indicated					
	the paramedics a	rrived around 6:15 P.M					
	[Doctor's name] Coumadin was n	dated 2/23/12: "Called to let him know that the ot held on 2/22/12He der) to hold it until after					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	CO	ATE SURVEY MPLETED	
	15G190	B. WING		03/	/30/2012	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	she has her lab drawn on Monday 2/27/12."					
	An interview with Direct Support Professional (DSP) A was conducted on 3/29/12 at 4:25 P.M DSP A indicated client A's 5 P.M. Coumadin was not held on 2/22/12 due to the group home staff not being informed to hold it before administering and further indicated the group home did not receive the memo from the nursing staff via e-mail until 2/27/12. DSP A further indicated she did not receive any training in regards to client A's identified medical needs since client A was moved to the group home on 2/11/12.					
	Further review of client A's record indicated: "Health Risk Plan dated 11/3/11-Client has diagnosis of hypertensionHealth Risk Plan dated 11/3/11-Client has diagnosis of hyperthyroidismHealth Risk Plan dated 11/3/11-Client has diagnosis of constipation and or bowel obstruction related to hyperthyroidismHealth Risk plan dated 11/3/11-Client is at risk for falls. Gait is unsteadyHealth Risk Plan dated 11/3/11-At risk for impaired circulation related to fractured clavicle."					
	A request for documentation to show all staff working at the group home and day					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G190	B. WIN	G		03/30/2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					ENUE C	
ARC OF	NORTHWEST INDI	IANA INC, THE		GRIFFI	TH, IN 46319	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ined on client A's				
	"Health Risk Plans" and health care needs					
		.8/12 at 2:30 P.M The				
	group home Licensed Practical Nurse (LPN) did not submit any documentation.					
		cumentation to show all				
	_	the group home and day				
		ined on client A's				
		ns" and health care needs				
		9/12 at 3:00 P.M The				
	group home LPN did not submit any					
	documentation.					
		cumentation to show all				
	_	the group home and day				
		ined on client A's				
		ns" was made on				
	3/30/12. The Set	rvice Coordinator and				
	group home LPN	I indicated there was no				
	documentation to	o indicate all group home				
	staff were trained	d on client A's "Health				
	Risk Plans" and	health care needs.				
	An interview wit	th Direct Support				
	,	SP) A was conducted on				
	3/29/12 at 4:25 P	P.M DSP A indicated				
	she never receive	ed any training on any of				
	client A's "Healt	h Risk Plans" or medical				
	concerns.					
	An interview wit	th DSP B was conducted				
	on 3/29/12 at 4:4	5 P.M DSP B				
	indicated she nev	ver received any training				

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	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G190	B. WIN			03/30/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ENUE C		
	NORTHWEST INDI			GRIFFI	TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	or medical conce	A's "Health Risk Plans"					
	of medical concerns.						
	An interview wit	h tha day program Ugalth					
	An interview with the day program Health and Safety Tech (HST) was conducted on						
	1						
		A.M The (HST) ntacted the nurse on					
		her aware of client A's					
	^ ~	and was directed to keep					
	1 -	the HST also indicated					
		e nurse later in the day to					
		of an injury of unknown					
	~ ~	was told to monitor her.					
		here were any incident					
		ted on the incidents the					
		" When asked if 911 was					
		f noticed the change in					
	client A's breathi	ing, the HST stated "No."					
	A i CUD.	-41.					
	A review of "Dea						
		lequete (sic) Care					
		7" was conducted on					
		P.M The record					
	indicated:						
	Interview with C	ervice Coordinator A					
		I got a phone call from					
		ne] staff on 2/23/12					
	1	were trying to reach the					
		not get a hold of her, that					
		mer bleeding but not					
		· ·					
	I -	f bleeding was indicated.					
	_	inator A name] told that					
	group home nur	se name] was at the					

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Event ID: FUPR11

Facility ID: 000722

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G190	B. WING		03/30/2012
		1		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	8		ENUE C	
ARC OF	NORTHWEST IND	IANA INC, THE		TH, IN 46319	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DDOWIDEDIC DE AN OF CORDECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	office, they said	they could not reach her.			
	I said I will have	her call you. Then I			
	called [group ho	me nurse name] at the			
	office I told her	about the request from			
	group home staf	f and she needs to call			
		near anything else until			
		23/12 when I got a call			
		ger. She said the group			
		to reach me because			
	consumer was g				
	_	mer was prescribed a			
	_	was moved temporarily to			
	[group home nat				
	Leroup nome nar	···•].			
	Interview with d	ay program DSP D dated			
		ked with [client A] on			
		ot on duty when she went			
		Prior to leaving day			
	_	seemed to be very weak			
	_	eted. Seeming to be			
	_	en [client A] came back			
	_	om hospital she was in a			
		seemed to be weak. No			
		to render services. I did			
		safety tech look at [client			
		fferent to me. When			
	_	in to me at 9:50 A.M.			
	_	a med error. I asked I			
	_				
		anything else and that her			
		g it was cleaned up and			
	nurse knew abou	ıt ıt."			
		2022			
		ay program DSP E dated			
	2/24/12: "I worl	xed with [client A]			

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Event ID: FUPR11

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE (COMPL	
MOLLAN	OI COMMENTON	15G190		LDING		03/30/	
		100100	B. WIN		DDDEGG GITY OT TE ZIP CORE	33/30/	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG				TAG	DLI ICILICI I		DATE
		/12I worked at the day					
		y. I noticed while that her breathing has					
	~	key to me and she was					
	_	eNo I was not trained					
	to render care for						
	to render care for	[CHOIL A].					
	Interview withda	y program DSP F datetd					
		ining for her (client A) in					
	particular."	ming for her (enem 71) in					
	particular.						
	Interview with da	ay program Health and					
		d 2/24/12: "I got a call					
	<u>-</u>	e residential nurse that					
		oup home had made an					
	_	r [client A], and were to					
		ne aware when they					
		the centerI knew in the					
	•	alf that [client A] was					
		and she wasn't herself					
	anymore, a little	more weak, less talkative					
	not smiling as m	uch, more quiet. Earlier					
	in the afternoon	I did check blood					
	pressure, because	e staff had mentioned that					
	she was breathin	g funny. Did take and it					
	was 113/77 pulse	e 61. Called the					
	residential nurse	about my concerns and					
	she said that was	okay for [client A].					
	Again I called he	er toward the time staff					
	was picking [clie	ent A] up to go home,					
	because her staff	had noticed a bruise on					
	the top of her hea	adI was told her					
	medication could	I cause her to have					
	unexplained brui	sing."					
	I .						

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	COMPLETED	
		15G190	B. WIN			03/30/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
	NORTHWEST INDI			120 AVE	ENUE C ГН, IN 46319		
					I II, III 403 19		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	Interview with D	OSP A dated 2/24/12:					
	"On February 23,	, 2012, [DSP A] came					
	into work at 4 P.1	M. at [Group home					
	name] where she	came in contact with					
	client A at 4:15 P	P.M [DSP A] was on					
	duty at the time the	he client went to the					
	hospital. [DSP A	a] states that the					
	consumer looked	pale and was slumped in					
	·	[DSP A] did not call for					
		e, another staff called.					
		as not alert or verbal					
	while in [DSP A]	's care. [DSP A] tried to					
	-	fted by placing her arm					
		s arm. [DSP A] came off					
	vacation on Mon	-					
		the group home, she had					
		on her[DSP A] had to					
		e from a different staff on					
	_	on of [client A] falling					
		es she tried to contact					
	_	ator name] on several					
		raining on consumer but					
		t answeredDid not see					
	•	house, but she did see					
	`	al Administration					
	Record)."						
	Interview with D	SP B dated 2/24/12:					
		d with client A last on					
	= =	SP B] was on duty when					
		nt to the hospital. [DSP					
		sumer was not acting her					
	_	sumer words were slured					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				
		15G190	B. WIN	G		03/30/2	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ENUE C		
ARC OF	NORTHWEST IND	IANA INC, THE		GRIFFI	ΓH, IN 46319		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	` ′	er barely said anything at					
		t normal. There was no					
	_	ures taken but [DSP B]					
		A's vital (sic) and found					
	that the consume	er's pulse low (it read 42).					
	[DSP B] called to	he emergency phone to					
		onsumer temperature was					
	90.5 degrees. Th	ne nurse instructed [DSP					
	B] to call 911. [1	DSP A and DSP B tried					
	to hold consume	r up in her wheelchair but					
	they never took l	ner out of chair. [DSP B]					
	states that she was not trained on meeting						
		onsumer[DSP B] have					
		isk plan at the house, but					
	there is a MAR."	-					
	there is a typ fit.						
	An interview wit	th the group home					
	Licensed Practic	al Nurse (LPN) was					
	conducted on 3/2	28/12 at 2:55 P.M The					
	LPN indicated sl	ne did not assess client A					
	after each incide	nt she was made aware					
	of. When asked	if client A was seen by a					
		ne mentioned incidents,					
		Io." When asked if the					
		A's arm bleeding on					
		umented, she stated "No."					
	When asked if 9	-					
		en the incidents of client					
	A's change in bro						
	occurred, the LP	•					
	occurred, the L1	11 billiod 110.					
	A review of the	facility's "Policy for					
		of Neglect and Abuse"					
		vas completed at the					
	1	1	ı				

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION (IDENTIFICATION NUMBER: 15G190	(X2) MULTIPLE CO A. BUILDING B. WING	00		SURVEY LETED 1/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	120 AV	ADDRESS, CITY, STATE, ZIP CO ENUE C TH, IN 46319)DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	facility's administrative office on 4/26/10 at 1:36 P.M., and indicated: "In order to protect the general welfare of the clients, [Facility name] has in effect the following policy with regard to abuse, neglect or exploitation of clients by agency staffprohibits all abuse, neglect and exploitation of our clientsStaff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedureNeglect is defied as knowingly placing a client in a situation that poses a threat to his/her health and well beingExamples include, but are not limited to depriving a client of food, clothing, shelter or medical care." A review of the facility's "When To Call A Nurse" policy/procedure no date, noted was conducted on 3/28/12 at 2:10 P.M The policy/procedure indicated: "The Nurse assigned to the group home is to be contacted regarding any changes in a client's medical condition. if no answer, leave a message and wait 30 minutes for a return call. If no return call in 30 minutes; call the nurse's emergency phoneCALL 911 FIRST (BEFORE CALLING THE NURSE), IF A CLIENT IS IN A LIFE-THREATENING SITUATION SUCH AS; UNCONTROLLED BLEEDING, DIFFICULTY BREATHING, SEVERE				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 03/30/2012			COMPLETED	
		15G190	B. WIN			03/30/2012	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ADC OF	NORTHWEST INDI	ANA INC. THE			ENUE C TH, IN 46319		
					1 H, IIN 403 19		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLET DATE	ION
IAG	CHEST PAIN, C	*		IAG	,	DATE	
	· · · · · · · · · · · · · · · · · · ·	ENESS. NOTIFY THE					
		E 911 CALL AS SOON					
	· ·	Anytime that you call a					
	1	g other than a question,					
	an incluent repor	t should be filled out."					
	Davies of the	Ala IIIndiana Ctata					
		A's "Indiana State					
	_	ealth Certificate of					
		8/12 was conducted on					
		P.M The document					
	indicated client A's cause of death was						
		rrest and she expired at					
	8:30 P.M. on 2/2	3/12.					
	No further docur	mented information was					
		iew to ensure that the					
		was monitoring the					
		of its Abuse and Neglect					
	-	edure and it's "When to					
	1	licy and procedure.					
	Cuii a i vaise po	no, and procedure.					
	The governing be	ody failed to exercise					
		nd operating direction					
	over the facility a						
	_	neglect policy and					
	_	vide timely health care for					
		d client (client A). Please					
	refer to W149.						
	10101 10 11 17.						
	This federal tag 1	relates to complaint					
	#IN00104522.	pp					
	9-3-1(a)						

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G190	A. BUILDING B. WING	00	COMPLETED 03/30/2012	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	

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Facility ID: 000722

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
THIND I LITTLE	or conduction	15G190	A. BUII			03/30/	
		100100	B. WIN	_	ADDRECC CITY CTATE ZIR CODE	00/00/	2012
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE 'ENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0111	recordkeeping sy client's health ca information, and rights. Based on record 1 of 1 discharged facility failed to describe the second to the second facility failed to describe the second facility facility failed to describe the second facility failed	develop and maintain a ystem that documents the re, active treatment, social protection of the client's review and interview for I client (client A), the ensure all pertinent	W0	111	Community Services Nurses was be re-trained by the Director of Health and Safety Services or new nursing protocols which winclude documentation, when assessments are required by nurse and or physician.	of n vill	04/29/2012
		gard to the client's health client's chart/records.					
	Findings include	:					
	office on 3/22/12 of client A's reco	facility's administrative 2 at 2:55 P.M A review ord failed to indicate any n 2/23/12 in regards to					
	dated 2/24/12: "I [group home nan stating that they	ervice Coordinator A I got a phone call from ne] staff on 2/23/12 were trying to reach the not get a hold of her, that					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		15G190	B. WING		03/30/2012
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
400.05	NODEL IMPORTANT	NAMA ING. THE		ENUE C	
ARC OF	NORTHWEST INC	DIANA INC, THE	GRIFF	ITH, IN 46319	
(X4) ID			ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL B. L. S.C. IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
TAG	1	R LSC IDENTIFYING INFORMATION)	TAG	DEFICE (*)	DATE
		amer bleeding but not			
	•	of bleeding was indicated.			
		dinator A name] told that			
		rse name] was at the			
	I -	they could not reach her.			
		e her call you. Then I			
		ome nurse name] at the			
		about the request from			
		ff and she needs to call			
		hear anything else until			
		23/12 when I got a call			
		ager. She said the group			
	I -	g to reach me because			
	consumer was g				
	_	imer was prescribed a			
		was moved temporarily to			
	[group home na	me]."			
	T., 4	1 DCD D 1.4. 1			
		day program DSP D dated			
		ked with [client A] on			
		not on duty when she went			
	_	Prior to leaving day			
	_	A] seemed to be very weak			
		eted. Seeming to be			
	_	nen [client A] came back			
		rom hospital she was in a			
		seemed to be weak. No			
	1 -	to render services. I did			
		safety tech look at [client			
	_	ifferent to me. When			
	_	r in to me at 9:50 A.M.			
	1	a med error. I asked if I			
		anything else and			
	informed that he	er arm was bleeding it was			

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PRINTED: 04/20/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 15G190	A. BUILDING B. WING	00	COMPLI - 03/30/	ETED
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	120 AV	ADDRESS, CITY, STATE, ZIP CO ENUE C TH, IN 46319	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	cleaned up and nurse knew about it." An interview with the LPN was conducted on 3/28/12 at 12:30 P.M The LPN indicated client A's was not assessed by the facility's nurse and she was not seen by a physician for the mentioned incident. The LPN further indicated there was no documentation in client A's record about her arm bleeding. This federal tag relates to complaint #IN00104522. 9-3-1(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
		15G190	B. WIN			03/30/	ZU 1Z
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC. THE			ENUE C TH, IN 46319		
			1		I	1	(X5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX (EAC)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE	
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
W0122	483.420						
	CLIENT PROTE						
		ensure that specific client					
	protections requi	rements are met.	$ _{W0}$	122	DCD's were trained on 4/5/12	00	04/29/2012
			WU	122	DSP's were trained on 4/5/12 on emergency interventions and appropriate reporting.		04/29/2012
	Based on record	review and interview, the			To ensure future compliance, a		
	Condition of Par	ticipation of Client			new staff will be trained before		
		not met as the facility			working with clients; all staff will be re-trained annually.	III	
	neglected to impl	lement their neglect			be to trained armidally.		
		cted to provide timely					
	health care for 1 of 1 deceased client						
	(client A).						
	Findings include	<u>.</u>					
	Please refer to W	149. The facility					
	neglected to impl	lement their neglect					
	policy and negled	cted to provide adequate					
	health care for cl	ient A who needed health					
	and emergency c	are interventions.					
		153. The facility failed					
	for 1 of 1 investi	gation record reviewed					
	involving 1 of 1	deceased client (client					
	A), to report imn	-					
	administrator and	d to the Bureau of					
	Developmental I	Disabilities Services					
	(BDDS) in accor	dance with state law.					
		7154. The facility failed					
	-	n evidence thorough					
	_	ere conducted for					
	incidents involvi	ng 1 of 1 deceased client					

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	OF CORRECTION OF CORRECTION 15G190	(X2) MULTIPLE CO A. BUILDING B. WING	00		SURVEY LETED 1/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	120 AV	ADDRESS, CITY, STATE, ZIP COD ENUE C TH, IN 46319	Е	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Please refer to W157. The facility failed to take effective corrective action to prevent client A's future occurrences of injury. This federal tag relates to complaint #IN00104522. 9-3-2(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G190	B. WING		03/30/2012
NAME OF I	PROVIDER OR SUPPLIEI		STREET .	ADDRESS, CITY, STATE, ZIP CODE	
				ENUE C	
ARC OF	NORTHWEST IND	IANA INC, THE	GRIFFI	TH, IN 46319	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0149	483.420(d)(1) STAFF TREATM	MENT OF CLIENTS			
		t develop and implement			
	· ·	and procedures that prohibit			
	mistreatment, ne	eglect or abuse of the client.	11/01/10		04/20/2012
			W0149	See W 104 page 3, W 111 pag 14	ge 04/29/2012
	Based on record	review and interview, the			
		d to implement their			
	, ,	nd neglected to provide			
		ency health care for 1 of			
		ent (client A), who needed			
	medical attention				
	incurcai attention	u.			
	Findings include	e:			
	A review of clie	nt A's record was			
	conducted on 3/2	22/12 at 2:55 P.M			
		A's medical record			
	indicated:				
	Nursing notation	n dated 1/9/12: "Received			
	_	phome (sic) staff Saturday			
		nt A] was coming down			
		down and passed out.			
	_	5 seconds later was aware			
		and time. Diagnosed			
		pe. Informed staff that			
		be a syncope episode and			
	* *	to monitor and walk with			
	-	possible." The record			
		e a "Health Risk Plan" for			
		nosis of syncope. Further			
	_	indicate a nursing			
	10 review failed to	murcate a nursing			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G190	B. WIN	G		03/30/2012
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
					ENUE C	
ARC OF	NORTHWEST INDI	IANA INC, THE		GRIFFI	TH, IN 46319	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		,		TAG	BEIGENCI	DATE
	assessment or a	a visit to the physician.				
	Namain a matatian	data d 2/6/12. UD and include				
		dated 2/6/12: "Received				
		on Sunday, 2/5/12 stating				
		as very weak and couldn't also lost control of her				
		der at the table and didn't				
		(Nurse) instructed staff				
	to have her trans	-				
	`	om) for evaluations and tx				
	(treatment). Admitted to hospital with UTI (Urinary Tract Infection) and blood					
	clot in left leg."					
	Nursing notation	dated 2/13/12:				
	"Discharged from					
		2. Came back with a new				
	1	din 5 mg (milligrams) qd				
	(everyday)."	Jan 1 1118 (111118) 111				
	Further review o	f the record indicated				
	client A was mov	ved to a different group				
		her discharge from the				
		12 due to her not being				
	_	l down stairs. No				
		vas available for review				
	to indicate all sta	aff at the group home				
		client A's medical needs.				
	Nursing notation	dated 2/22/12:				
	"Received a call from [Doctor's name]					
	office with a verbal order to hold					
	Coumadin for 3	days and have blood				
		y due to high levels. Sent				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
11112 12111	or confidence.	15G190		LDING		03/30/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE		GRIFFI [*]	TH, IN 46319		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		se with instruction to		TAG	DEFICIENCY)		DATE
	hold the medication and sent the lab order to take on Saturday when they have her						
	lab drawn."	ay when they have her					
	ido didwii.						
	An interview wit	h Direct Support					
	Professional (DS	P) B was conducted on					
	3/29/12 at 4:45 P	P.M DSP B indicated					
	client A's 5 P.M.	Coumadin was not held					
		the group home staff					
	_	of the order and not					
	_	mo from the nursing staff					
		2/27/12. DSP B further					
		not receive any training					
		nt A's identified medical t A was moved to the					
	group home on 2						
	group nome on 2	/11/12.					
	Nursing notation	dated 2/23/12:					
	"Received a call	from health tech stating					
	that [client A] ha	d an episode at					
	workshop where	she was breathing hard					
		s. Vitals were taken and					
	,	in normal limits). She					
		d normal now and that it					
	_	seconds. I instructed her					
		it again or if she had any					
		No further documentation					
		review in the record to					
		g assessment or to it was sent to a physician					
		t of the noted concerns.					
	201 411 455055111011	. of the noted concerns.					
	Nursing notation	dated 2/23/12:					

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 03/30	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE	
	stating that there [client A]'s head was there this mode documentation win the record to it assessment or to sent to a physicia the noted bruise. An interview with on 3/29/12 at 5:5 when she picked workshop on 2/2 acting herself, with seemed weak. Docient A back into assigned staff and with her. The day client A would not be client A was not client A was not client A was not client A was not client A was a bruise she notice be called the ginformed her of the called the ginformed her of the group home a state of the group home as the client A was acting. Dot directives were gintered the group home as the client A was acting.	indicate the client was in for an assessment of						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G190	B. WIN			03/30/2012
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE	
ARC OF	NORTHWEST IND	IANA INC. THE			ENUE C TH, IN 46319	
			1	ID	111, 114 40010	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	documented this	information on an				
ı	incident report D	OSP C stated "No,				
	because there was no significant injury."					
	When asked if 9	11 was contacted she				
	stated "No."					
	Nursing notation					
		rom group home staff				
	_	t was not acting herself.				
	Client was able to answer questions when asked from staff. Instructed staff to take					
		nd call me backStaff				
		wnl (within normal				
	· ·	t was not answering any				
	•	aff stated that client eyes				
		ving from side to side. I				
		o call 911. Client was				
		Iospital name] for				
	evaluation and tr	reatment."				
	An interview wit	th DSP A was conducted				
	on 3/29/12 at 4:2					
		client A was dropped off				
		ne at 4:15 P.M., she was				
	1 .	f. DSP A indicated client				
	_	and was slouched in her				
	wheelchair. DSI	P A indicated three				
	attempts were m	ade to contact the group				
	_	Service Coordinator, but				
	neither could be reached. DSP A indicated DSP B then called the					
	emergency nursi	ng phone. When the on				
	call nurse called	back around 6:00 P.M.,				
	they informed he	er client A's condition of				

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190		LDING	NSTRUCTION 00	(X3) DATE COMPL 03/30	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE	
	her wheelchair. directed the staff and call her back taken and they re 47 and a temperate home staff then compared back and as they A's vitals, client the back of her had the paramedics at the paramedic at the parame	talk and her slouching in The on call nurse to take client A's vitals at Client A's vitals were and 163/99 with a pulse of ature of 90.5. The group called the on call nurse were giving her client A's eyes began rolling in ead. DSP A indicated on call nurse gave 911. DSP A indicated rrived around 6:15 P.M dated 2/23/12: "Called to let him know that the ot held on 2/22/12He der) to hold it until after rawn on Monday th Direct Support (P) A was conducted on P.M DSP A indicated Coumadin was not held to the group home staff ed to hold it before d further indicated the not receive the memo staff via e-mail until further indicated she did raining in regards to fied medical needs since wed to the group home on						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		15G190	B. WIN			03/30/2012	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE		GRIFFI	TH, IN 46319		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	2/11/12.						
		f client A's record					
	indicated: "Health Risk Plan dated						
	11/3/11-Client ha	as diagnosis of					
	hypertensionH	ealth Risk Plan dated					
	11/3/11-Client ha	as diagnosis of					
	hyperthyroidism	Health Risk Plan dated					
	11/3/11-Client ha	as diagnosis of					
	constipation and	or bowel obstruction					
	related to hyperthyroidismHealth Risk						
		11-Client is at risk for					
	falls. Gait is uns	teadyHealth Risk Plan					
		trisk for impaired					
		d to fractured clavicle."					
	A request for doo	cumentation to show all					
	staff working at t	the group home and day					
	services were tra	ined on client A's					
	"Health Risk Pla	ns" and health care needs					
	was made on 3/2	8/12 at 2:30 P.M The					
	group home Lice	ensed Practical Nurse					
	1 ~ ^	bmit any documentation.					
		,					
	A request for doo	cumentation to show all					
		the group home and day					
	-	ined on client A's					
		ns" and health care needs					
		9/12 at 3:00 P.M The					
		I did not submit any					
	documentation.	, and not busine uny					
	documentation.						
	Δ request for do	cumentation to show all					
	_						
	j stari working at i	the group home and day	I			ĺ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G190	B. WIN	G		03/30/2	2012
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
4 DO OF	NODEL WATER IND	IANIA INIO TUE			ENUE C		
ARC OF	NORTHWEST IND			GRIFFI	TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		nined on client A's		1110			DATE
		ins" was made on					
	3/30/12. The Service Coordinator and						
		N indicated there was no					
		o indicate all group home					
		d on client A's "Health					
		health care needs.					
	An interview wit	th Direct Support					
	Professional (DS	SP) A was conducted on					
	3/29/12 at 4:25 I	P.M DSP A indicated					
	she never receive	ed any training on any of					
	client A's "Healt	h Risk Plans" or medical					
	concerns.						
		th DSP B was conducted					
	on 3/29/12 at 4:4						
		ver received any training					
	1	A's "Health Risk Plans"					
	or medical conce	erns.					
		al al 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
		th the day program Health					
	1	(HST) was conducted on					
		A.M The (HST) ntacted the nurse on					
		her aware of client A's					
		and was directed to keep					
	1 .	The HST also indicated					
	I -	e nurse later in the day to					
		of an injury of unknown					
		was told to monitor her.					
		nere were any incident					
		ated on the incidents the					
	_	" When asked if 911 was					
	<u> </u>						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE (COMPL		
THIND TETHIN	or condition	15G190		LDING		03/30/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	30,00	
NAME OF P	PROVIDER OR SUPPLIER				ENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		f noticed the change in					
	chent A's breathi	ng, the HST stated "No."					
	A review of "Dea	ath					
	Investigation-Ad	equete (sic) Care					
	Rendered #1686	7" was conducted on					
	3/30/12 at 12:07	P.M The record					
	indicated:						
	1	an in Constitution A					
		ervice Coordinator A					
		I got a phone call from					
		ne] staff on 2/23/12					
		were trying to reach the					
		not get a hold of her, that					
		mer bleeding but not					
	-	f bleeding was indicated.					
	-	inator A name] told that					
		se name] was at the					
		they could not reach her.					
		her call you. Then I					
		me nurse name] at the					
		about the request from					
		f and she needs to call					
		near anything else until					
		3/12 when I got a call					
		ger. She said the group					
		to reach me because					
	consumer was go	•					
	-	mer was prescribed a					
		vas moved temporarily to					
	[group home nan	nej."					
	Interview with d	ay program DSP D dated					
		ted with [client A] on					
							<u>. </u>

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 03/30		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	to the hospital. It service [client A when being toile spaced out Whe to day service from wheelcahir and sepecial training thave health and sepecial training that the sepecial training that the sepecial training training that the sepecial training training that the sepecial training training	ay program DSP E dated ted with [client A] /12I worked at the day ay. I noticed while that her breathing has key to me and she was neNo I was not trained						

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190		A. BUILDING 00			COMPLETED 03/30/2012	
		100100	B. WIN			00/00/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE	120 AVENUE C GRIFFITH, IN 46319				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Έ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ne aware when they					
	_	the centerI knew in the					
		lf that [client A] was					
	_	and she wasn't herself					
		more weak, less talkative					
	_	uch, more quiet. Earlier					
	in the afternoon I						
	pressure, because	e staff had mentioned that					
	she was breathing	g funny. Did take and it					
	was 113/77 pulse	e 61. Called the					
	residential nurse	about my concerns and					
	she said that was	okay for [client A].					
	Again I called he	r toward the time staff					
	was picking [clie	nt A] upto go home,					
	because her staff	had noticed a bruise on					
	the top of her hea	ndI was told her					
	-	cause her to have					
	unexplained bruis	sing."					
	1						
	Interview with D	OSP A dated 2/24/12:					
	"On February 23.	, 2012, [DSP A] came					
		M. at [Group home					
		came in contact with					
	_	P.M [DSP A] was on					
		he client went to the					
	hospital. [DSP A						
		pale and was slumped in					
		[DSP A] did not call for					
	_	e, another staff called.					
		as not alert or verbal					
		's care. [DSP A] tried to					
		fted by placing her arm					
	_	s arm. [DSP A] came off					
	vacation on Mon	uay 2/20/12 anu					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE (COMPL	
ANDILAN	OI COMMECTION	15G190		LDING		03/30/	
		100100	B. WIN		DDDEGG CITY OTLTE GROODE	33/30/	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		the group home, she had		TAG	Dia lettike 1		DATE
		on her[DSP A] had to					
		e from a different staff on					
		on of [client A] falling					
	_	tes she tried to contact					
		nator name] on several					
	-	training on consumer but					
	_	et answeredDid not see					
		house, but she did see					
	-	cal Administration					
	Record)."						
	,						
	Interview with D	SP B dated 2/24/12:					
	"[DSP B] worked	d with client A last on					
		SP B] was on duty when					
	the consumer we	ent to the hospital. [DSP					
	B] states the cons	sumer was not acting her					
	normal self. Cor	nsumer words were slured					
	(sic) but consum	er barely said anything at					
	all which was no	t normal. There was no					
	life saving measu	ares taken but [DSP B]					
	did check client	A's vital (sic) and found					
		er's pulse low (it read 42).					
		he emergency phone to					
	•	onsumer temperature was					
		instructed [DSP B] to					
	_	A and DSP B tried to hold					
	•	ner wheelchair but they					
		at of chair. [DSP B]					
		as not trained on meeting					
		onsumer[DSP B] have					
	` /	isk plan at the house, but					
	there is a MAR."						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	COMPL	
ANDILAN	OI COMMECTION	15G190		LDING		03/30/	
		100100	B. WIN		DDDEGG CITY OT TE TO COSE	33/30/	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN			(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		th the group home					
		al Nurse (LPN) was					
		28/12 at 2:55 P.M The					
		ne did not assess client A					
		nt she was made aware					
		if client A was seen by a					
		ne mentioned incidents,					
		Io." When asked if the					
		A's arm bleeding on					
		umented, she stated "No."					
	When asked if 9						
immediately when the incidents of client							
	A's change in breathing incidents						
	occurred, the LP	N stated "No."					
	A review of the f	facility's "Policy for					
	Handling Cases	of Neglect and Abuse"					
	dated 12/20/06 w	vas completed at the					
	facility's adminis	strative office on 3/30/12					
	at 12:15 P.M., an	nd indicated: "In order to					
	protect the gener	al welfare of the clients,					
	[Facility name] h	nas in effect the following					
	policy with regar	d to abuse, neglect or					
	exploitation of cl	lients by agency					
	staffprohibits a	ll abuse, neglect and					
	exploitation of or	ur clientsStaff will					
	immediately repo	ort any allegations of					
	abuse, neglect or	exploitation of our					
	clients per agenc	y reporting					
	procedureNegl	ect is defined as					
	-	ng a client in a situation					
		nt to his/her health and					
	-	nples include, but are not					
	_	ving a client of food,					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190		00	03/30	LETED 0/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	120 AV	ADDRESS, CITY, STATE, ZIP ENUE C TH, IN 46319	CODE	_
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	clothing, shelter or medical care." Review of client A's "Indiana State Department of Health Certificate of Death" dated 3/28/12 was conducted on 3/30/12 at 1:30 P.M The document indicated client A's cause of death was sudden cardiac arrest and she expired at 8:30 P.M This federal tag relates to complaint #IN00104522. 9-3-2(a)				

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PRINTED: 04/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE (COMPL	
ANDILAN	or connection	15G190	A. BUII		00	03/30/	
		130 130	B. WIN			03/30/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			'ENUE C ITH, IN 46319		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0153	483.420(d)(2) STAFF TREATM The facility must mistreatment, ne injuries of unknow immediately to the officials in accord established proce Based on record of facility failed for records reviewed discharged client immediately to the the Bureau of De Services (BDDS) law. Findings include A review of client conducted on 3/2 Review of client indicated: Nursing notation "Discharged from Saturday 2/11/12 order for Coumac (everyday)."	ensure that all allegations of glect or abuse, as well as wn source, are reported the administrator or to other dance with State law through reduces. The ensure that all allegations of glect or abuse, as well as wn source, are reported the administrator or to other dance with State law through reduces. The ensure that all allegations of the end interview, the second involving 1 of 1 o	W0		See W 104 page 3, W 111 page 14 Community Services Nurse will be trained on appropriate BDDS reporting. To ensure future compliance, Director of Health and Safety services will monitor weekly for three weeks and monthly thereafter.	the	04/29/2012
	office with a vert	out order to noid					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190	(X2) MULTIPLE C A. BUILDING B. WING	OONSTRUCTION 00	COM	TE SURVEY MPLETED 30/2012
	PROVIDER OR SUPPLIER		STREET 120 A	TADDRESS, CITY, STATE, ZIF VENUE C FITH, IN 46319	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	drawn on 4th day memo to the hou hold the medicat	days and have blood due to high levels. Sent se with instruction to ion and sent the lab order ay when they have her				
	3/29/12 at 4:45 P client A's 5 P.M. on 2/22/12 due to not being aware or receiving the me via e-mail until 2 was available for documentation w to indicate the ad	P) B was conducted on P.M DSP B indicated Coumadin was not held to the group home staff of the order and not mo from the nursing staff 1/27/12. No BDDS report the review. No was available for review				
	[Doctor's name] Coumadin was n stated (verbal ord she has her lab d 2/27/12." No BI for review. No d available for revi	dated 2/23/12: "Called to let him know that the ot held on 2/22/12He der) to hold it until after rawn on Monday DDS report was available ocumentation was ew to indicate the s immediately notified of				
	`	h Direct Support P) A was conducted on P.M DSP A indicated				

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Facility ID: 000722

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G190	B. WING		03/30/2012
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		ADDRESS, CITY, STATE, ZIP CODE	
				ENUE C	
ARC OF	NORTHWEST IND	IANA INC, THE	GRIFFI	TH, IN 46319	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	+	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		. Coumadin was not held			
		o the group home staff			
	•	ned to hold it before			
	_	d further indicated the			
	• •	not receive the memo			
	-	staff via e-mail until			
		DS report was available			
		documentation was			
		iew to indicate the			
		as immediately notified of			
	this incident.				
	A review of "De	ath			
	Investigation-Ac	lequete (sic) Care			
	Rendered #1686	7" was conducted on			
	3/30/12 at 12:07	P.M The record			
	indicated:				
	Interview with S	ervice Coordinator A			
	dated 2/24/12: "	I got a phone call from			
	[group home nar	me] staff on 2/23/12			
	stating that they	were trying to reach the			
	nurse but could i	not get a hold of her, that			
	was about consu	mer bleeding but not			
	badly, location of	of bleeding was indicated.			
	-	linator A name] told that			
	_	rse name] was at the			
		they could not reach her.			
	· ·	her call you. Then I			
		me nurse name] at the			
		about the request from			
	group home staff and she needs to call				
		near anything else until			
		23/12 when I got a call			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G190	B. WIN	IG		03/30/2	2012
NAME OF I	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIO TUE			ENUE C		
ARC OF	NORTHWEST IND	IANA INC, THE		GRIFFI	TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		<u> </u>	+	TAG		<u> </u>	DATE
		ger. She said the group					
	home was trying to reach me because consumer was going to the						
		mer was prescribed a					
	-	was moved temporarily to					
		ne]." No BDDS report					
	was available for						
		vas available for review					
	to indicate the ac						
		ified of this incident.					
	ininiculately not	ined of this incident.					
	Interview with day program DSP D dated						
		ked with [client A] on					
		staff brought her in to me					
		y told me of a med error.					
	l '	to know anything else					
		was bleeding it was					
		urse knew about it." No					
		s available for review.					
	_	on was available for					
		e the administrator was					
		ified of this incident.					
	Interview with d	ay program Health and					
		ed 2/24/12: "I got a call					
	1	e residential nurse that					
	<u>-</u>	oup home had made an					
	_	or [client A], and were to					
		me aware when they					
		the center." No BDDS					
	_	able for review. No					
	-	vas available for review					
	to indicate the ac	lministrator was					
	immediately not	ified of this incident.					

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		IDENTIFICATION NUMBER: 15G190		LDING	00	COMPL 03/30/	ETED	
	PROVIDER OR SUPPLIER	ANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	conducted on 3/2 LPN indicated shafter each incider of. When asked in physician after the LPN stated "I incident of client 2/23/12 was door the administrator "No." When asked was immediately administrator and "No." An interview was Service Coordinal administrative of P.M The SC induction in the properties of the p	al Nurse (LPN) was 8/12 at 2:55 P.M The e did not assess client A at she was made aware f client A was seen by a e mentioned incidents, No." When asked if the A's arm bleeding on amented and reported to and BDDS, she stated ed if the medication error reported to the BDDS, the LPN stated at conducted with the tor (SC) at the facility's fice on 3/28/12 at 2:20 dicated incidents are to						

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 15G190	(X2) MULTIPLE CO A. BUILDING B. WING	00	- COM 03/3	TE SURVEY SPLETED 30/2012		
ARC OF	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE S COMPL 03/30/	ETED	
	PROVIDER OR SUPPLIEF		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ENUE C TH, IN 46319	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
W0318	-	SERVICES ensure that specific health quirements are met.	W0	318	See W 104 page 3, W 111 page 14	ge	04/29/2012
	Condition of Par Services, is not r to provide adequ	ices for 1 of 1 deceased					
	Findings include	:					
	for 1 of 1 dischar not ensuring clie	7331. The facility failed rged client (client A) by ent A received nursing services according to her					
	for 1 of 1 discha	7339. The facility failed rged client (client A), to or her diagnosis of					
	nursing services	7340. The facility failed to assure staff were care needs for 1 of 1 t (client A).					
		7368. The facility failed discharged client (client					

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PRINTED: 04/20/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G190	A. BUILDING B. WING	00	COMPl - 03/30			
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	A), received medications in compliance with the physician's orders.						
	This federal tag relates to complaint #IN00104522.						
	9-3-6(a)						

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Facility ID: 000722

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			00	· 1	LETED
		15G190	A. BUII B. WIN)/2012
			B. WIN	_	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			120 A	AVENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE		GRIF	FITH, IN 46319		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION
W0331	483.460(c)	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!)		DATE
***************************************	NURSING SERV						
	The facility must provide clients with nursing services in accordance with their needs.						
			W0	331	See W 104 page 3, W 111	nane	04/29/2012
			""	551	14	page	04/25/2012
		review and interview, the					
	_	1 of 1 discharged client					
	` ′	are she received nursing					
		rgency care according to					
	her medical need	S.					
	Findings include						
	Tilldings illetude.	•					
	A review of clien	nt A's record was					
		2/12 at 2:55 P.M					
	Review of client	A's medical record					
	indicated:						
		dated 1/9/12: "Received					
		phome (sic) staff Saturday					
		nt A] was coming down					
	•	down and passed out.					
		5 seconds later was aware					
		and time. Diagnosed					
		e. Informed staff that be a syncope episode and					
		o monitor and walk with					
	,	possible." Further review					
		a nursing assessment or					
	a visit to the phys	_					
	Nursing notation	dated 2/6/12: "Received					
	a call from staff of	on Sunday, 2/5/12 stating					

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 03/30	ETED
	PROVIDER OR SUPPLIER			120 AVE	DDRESS, CITY, STATE, ZIP CODE ENUE C FH, IN 46319	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	stand at all. She bowels and bladdeven realize it. It to have her trans (Emergency Root (treatment). Adr UTI (Urinary Traclot in left leg." Nursing notation "Discharged from Saturday 2/11/12 order for Couma (everyday)." Further review of client A was more than the day of thospital on 2/11/12 able to go up and documentation with to indicate all states were trained on the coumand of the coumand of the hour and the day of the coumand of the hour hold the medicate and the coumand of the hour hold the medicate and the country and the coumand of the hour hold the medicate and the country	mi) for evaluations and tx mitted to hospital with act Infection) and blood dated 2/13/12: In the hospital on Came back with a new din 5 mg (milligrams) qd of the record indicated wed to a different group her discharge from the 12 due to her not being I down stairs. No was available for review off at the group home client A's medical needs. dated 2/22/12: from [Doctor's name]					

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	OF CORRECTION OF CORRECTION 15G190 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/30/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	120 AV	ADDRESS, CITY, STATE, ZIP CODE ENUE C TH, IN 46319	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	An interview with Direct Support Professional (DSP) B was conducted on 3/29/12 at 4:45 P.M DSP B indicated client A's Coumadin was not held on 2/22/12 due to the group home staff not receiving the memo from the nursing staff via e-mail until 2/27/12. DSP B further indicated she did not receive any training in regards to client A's identified medical needs since client A was moved to the group home on 2/11/12. Nursing notation dated 2/23/12: "Received a call from health tech stating that [client A] had an episode at workshop where she was breathing hard for a few seconds. Vitals were taken and were WNL (within normal limits). She stated she seemed normal now and that it only lasted a few seconds. I instructed her to call if she did it again or if she had any odd behavior." No further documentation was available for review in the record to indicate a nursing assessment or to indicate the client was sent to a physician for an assessment of the noted concerns. Nursing notation dated 2/23/12: "Received a call from North (workshop) stating that there was a small bruise on [client A]'s head that they don't believe was there this morning." No further documentation was available for review			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190			LDING	NSTRUCTION 00	(X3) DATE COMPL 03/30/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ENUE C FH, IN 46319	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
		ndicate a nursing indicate the client was in for an assessment of					
	on 3/29/12 at 5:5 when she picked workshop on 2/2 acting herself, we seemed weak. Do client A back into assigned staff and with her. The date client A was not client A would not be described by the Health and Schow client was a bruise she notice DSP C indicated Tech called the grant informed her of the A was acting. Do directives were grants.	h DSP C was conducted 0 P.M DSP C indicated client A up from 3/12, client A was not as not able to talk and SP C stated she walked to the day program to her d asked what was wrong y program staff told DSP acting herself all day and to eat her lunch which was not normal for then walked client A to afety Tech to show her ad on client A's head. The Health and Safety group home nurse and the injury and how client SP C indicated no given by the group home en transported client A to and dropped her off to ft.					
	stating that client	dated 2/23/12: om group home staff t was not acting herself. o answer questions when					

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 03/30	LETED
	PROVIDER OR SUPPLIER		_ !	120 AVE	DDRESS, CITY, STATE, ZIP CODE ENUE C FH, IN 46319		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	asked from staff. her v/s (vitals) are returned call v/s limits), but client questions and state were rapidly more instructed staff to transported to [Hevaluation and transported to [Hevalua	Instructed staff to take and call me backStaff with within normal at was not answering any off stated that client eyes wing from side to side. It is call 911. Client was cospital name] for eatment." The DSP A was conducted 5 P.M DSP A lient A was dropped off e at 4:15 P.M., she was f. DSP A indicated client and was slouched in her of A indicated three ade to contact the group Service Coordinator, but reached. DSP A then called the ing phone and when the ed back they informed indition of not being able					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/30/2012
	PROVIDER OR SUPPLIEI		120 AV	ADDRESS, CITY, STATE, ZIP CODE ENUE C TH, IN 46319	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	call 911. DSP A	nurse gave directives to indicated the yed around 6:15 P.M			
	[Doctor's name] Coumadin was r stated (verbal or	n dated 2/23/12: "Called to let him know that the not held on 2/22/12He der) to hold it until after drawn on Monday			
	Professional (DS 3/29/12 at 4:25 ld client A's Coum 2/22/12 due to the receiving the median e-mail until 2 indicated she did in regards to client A:20 ld cl	th Direct Support SP) A was conducted on P.M DSP A indicated adin was not held on the group home staff not terms from the nursing staff 2/27/12. DSP A further all not receive any training tent A's identified medical and A was moved to the 2/11/12.			
	indicated: "Hea 11/3/11-Client h hypertensionH 11/3/11-Client h hyperthyroidism 11/3/11-Client h constipation and related to hypert plan dated 11/3/	ealth Risk Plan dated as diagnosis of Health Risk Plan dated			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00		SURVEY LETED 1/2012
	PROVIDER OR SUPPLIER		p. winte	STREET A	ddress, city, state, zip cod ENUE C FH, IN 46319	Е	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
		risk for impaired d to fractured clavicle."					
	staff working at a services were tra "Health Risk Pla was made on 3/2 group home Lice (LPN) did not su A request for doo staff working at a services were tra "Health Risk Pla was made on 3/2	the group home and day ined on client A's ns" and health care needs 8/12 at 2:30 P.M The ensed Practical Nurse bmit any documentation. cumentation to show all the group home and day ined on client A's ns" and health care needs 9/12 at 3:00 P.M The I did not submit any					
	A request for door staff working at a services were tra "Health Risk Pla 3/30/12. The Sergroup home LPN documentation to staff were trained Risk Plans" and Man interview with Professional (DS 3/29/12 at 4:25 F she never received)	cumentation to show all the group home and day ined on client A's ns" was made on rvice Coordinator and I indicated there was no o indicate all group home d on client A's "Health health care needs. th Direct Support P. A was conducted on P.M DSP A indicated ed any training on any of th Risk Plans" or medical					

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Event ID: FUPR11

Facility ID: 000722

If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G190	B. WIN			03/30/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
APC OF	NORTHWEST INDI	IANIA INIC THE			ENUE C TH, IN 46319	
					111, 111 40319	1
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	concerns.					
	Concerns.					
	An interview wit	th DSP B was conducted				
	on 3/29/12 at 4:4					
	indicated she nev	ver received any training				
		A's "Health Risk Plans"				
	or medical conce					
	A review of "Dea	ath				
	Investigation-Adequete (sic) Care					
	Rendered #16867" was conducted on					
	3/30/12 at 12:07 P.M The record					
	indicated:					
	Interview with S	ervice Coordinator A				
	dated 2/24/12: "	I got a phone call from				
	[group home nan	ne] staff on 2/23/12				
		were trying to reach the				
		not get a hold of her, that				
		mer bleeding but not				
		f bleeding was indicated.				
	_	inator A name] told that				
		se name] was at the				
	1	they could not reach her.				
		her call you. Then I				
		me nurse name] at the				
		about the request from				
		f and she needs to call				
		near anything else until				
		3/12 when I got a call				
		ger. She said the group				
		to reach me because				
	consumer was go	_				
	hospitalConsur	mer was prescribed a				

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AND PLAN OF (CORRECTION	IDENTIFICATION NUMBER:					
		150100	A. BUIL	DING	00	COMPL	
		15G190	B. WING	G		03/30/	2012
NAME OF PRO	VIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
450 05 110		ANIA INIO TIJE		120 AVE			
ARC OF NO	DRTHWEST INDIA	ANA INC, THE		GRIFFII	ΓH, IN 46319		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		as moved temporarily to					
[8	[group home name]."						
Ir 2/2 to see we specified to	nterview with da 2/24/12: "I worke 2/23/12. I was not to the hospital. Pervice [client A] when being toilet paced out When to day service frow wheelcahir and seepecial training to have health and say she looked differ they told me of a needed to know a narm was bleeding nurse knew about the triview with day 2/24/12: "I worked working with her always been shake hirsty all the time to render care for	ay program DSP D dated ed with [client A] on of the on duty when she went writer to leaving day seemed to be very weak ed. Seeming to be in [client A] came back im hospital she was in a seemed to be weak. No of render services. I did after tech look at [client after to me. When in to me at 9:50 A.M. in med error. I asked I anything else and that her is it was cleaned up and it it." The program DSP E dated ed with [client A] 12I worked at the day by. I noticed while that her breathing has seen to me and she was eNo I was not trained [client A]." The program DSP F dated electron on the was even me and she was eNo I was not trained [client A]."					

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AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190		A. BUII	LDING	00	COMPL 03/30/	ETED
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF P	ROVIDER OR SUPPLIER				ENUE C		
ARC OF	NORTHWEST INDI				TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ny program Health and					
	-	d 2/24/12: "I got a call					
	•	e residential nurse that					
		oup home had made an					
		r [client A], and were to					
		ne aware when they					
	_	the centerI knew in the					
		alf that [client A] was					
	_	and she wasn't herself					
		more weak, less talkative					
	not smiling as much, more quiet. Earlier						
	in the afternoon I did check blood						
	pressure, because staff had mentioned that						
		g funny. Did take and it					
	was 113/77 pulse						
		about my concerns and					
		okay for [client A].					
	_	r toward the time staff					
		nt A] upto go home,					
		had noticed a bruise on					
	-	ndI was told her					
		cause her to have					
	unexplained bruis	sing."					
		OSP A dated 2/24/12:					
		, 2012, [DSP A] came					
		M. at [Group home					
	_	came in contact with					
		P.M [DSP A] was on					
	_	he client went to the					
	hospital. [DSP A	-					
		pale and was slumped in					
	-	[DSP A] didi not call for					
	for help of anyon	e, another staff called.					

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AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190		A. BUII	LDING	00	COMPL 03/30/	ETED
		100100	B. WIN		DDDEGG OUTV CTATE ZID CODE	00/00/	20.2
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		as not alert or verbal					
		s care. [DSP A] tried to					
	_	fted by placing her arm					
		s arm. [DSP A] came off					
	vacation on Mon	-					
		the group home, she had					
		on her[DSP A] had to					
		e from a different staff on					
	-	on of [client A] falling					
		es she tried to contact					
	[Service Coordinator name] on several						
	occasions to get training on consumer but						
		t answeredDid not see					
	_	house, but she did see					
		eal Administration					
	Record)."						
		SP B dated 2/24/12:					
	"[DSP B] worked	d with client A last on					
	4/23/12 (sic) [DS	SPB] was on duty when					
	the consumer we	nt to the hospital. [DSP					
	B] states the cons	sumer was not acting her					
	normal self. Con	sumer words were slured					
	(sic) but consume	er barely said anything at					
	all which was no	t normal. There was no					
	life saving measu	res taken but [DSP B]					
	did check client A	A's vital (sic) and found					
	that the consume	r's pulse low (it read 42).					
	[DSP B] called the	ne emergency phone to					
	report that the co	nsumer temperature was					
	_	instructed [DSP B] to					
		A and DSP B tried to hold					
		er wheelchair but they					
	*	it of chair. [DSP B]					
			1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE (COMPL		
MINDILMIN	or conduction	15G190		LDING		03/30/	
		100100	B. WIN			00/00/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ENUE C		
ARC OF	NORTHWEST INDI	IANA INC, THE			TH, IN 46319		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		as not trained on meeting					
		onsumer[DSP B] have					
	(sic) not seen a risk plan at the house, but						
	there is a MAR."						
	An interview wit	h the group home					
		al Nurse (LPN) was					
		28/12 at 2:55 P.M The					
	LPN indicated sh	ne did not assess client A					
		nt she was made aware					
		if client A was seen by a					
	physician after the mentioned incidents,						
		Io." When asked if the					
		A's arm bleeding on					
		umented, she stated "No."					
	Review of client	A's "Indiana State					
	Department of H	ealth Certificate of					
	Death" dated 3/2	8/12 was conducted on					
	3/30/12 at 1:30 P	P.M The document					
	indicated client A	A's cause of death was					
	sudden cardiac a	rrest and she expired at					
	8:30 P.M. on 2/2	3/12.					
	This federal tag i	relates to complaint					
	#IN00104522.	_					
	9-3-6(a)						

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PRINTED: 04/20/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G190	A. BUILDING B. WING		COMPLETED 03/30/2012
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
	NORTHWEST INDI			ENUE C TH, IN 46319	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	, , , , , , , , , , , , , , , , , , ,				

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Event ID: FUPR11

Facility ID: 000722

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		15G190	B. WIN			03/30/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE		GRIFFI	TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0339	483.460(c)(4) NURSING SERV	/ICES					
		must include other nursing					
	care as prescribe	ed by the physician or as					
	identified by clier	nt needs.					
			W0:	339	See W 104 page 3, W 111 pag	ge	04/29/2012
					14		
	Racad on record	review and interview, the					
		1 of 1 discharged client					
		relop a plan for her					
	` ''	• •					
	diagnosis of sync	cope.					
	F: 1: · · 1 1						
	Findings include:						
	A	-4 Ala					
	A review of clier						
		22/12 at 2:55 PM. Client					
		ted a nursing notation					
		ch indicated: "Received					
		bhome (sic) staff Saturday					
		nt A] was coming down					
	•	down and passed out.					
		5 seconds later was aware					
		and time. Diagnosed					
		e. Informed staff that					
		be a syncope episode and					
	-	o monitor and walk with					
		possible." Further review					
		ed to indicate a risk plan					
	for client A's diag	gnosis of syncope.					
		h the group home					
		al Nurse (LPN) was					
		28/12 at 1:45 P.M The					
	LPN stated "The	re was no syncope risk					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		15G190	B. WING		03/30/2012	
	PROVIDER OR SUPPLIER NORTHWEST IND		120 AV	ADDRESS, CITY, STATE, ZIP CODE 'ENUE C ITH, IN 46319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	for syncope." W was she stated "S doesn't get to the spells." No furth available for rev	pecause there is no cure Then asked what syncope Syncope is when oxygen brain and causes fainting ner documentation was iew to indicate a risk plan ped for client A's cope.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G190	B. WING	3		03/30/	2012
NAME OF D	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			120 AVI	ENUE C		
	NORTHWEST INDI				TH, IN 46319		
(X4) ID		FATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG W0340		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0340	with other memb team, appropriate health measures	rices must include implementing ers of the interdisciplinary e protective and preventive that include, but are not g clients and staff as needed					
	in appropriate he	alth and hygiene methods.					
			W03	340	See W 104 page 3, W 111 pag 14	ge	04/29/2012
	facility nursing sestaff were trained 1 of 1 discharged Findings include A review of client conducted on 3/2 Review of client indicated: Nursing notation a call from group stating that [client the steps and sat Came to about 45 of person, place a 3/11 with syncop this appeared to be just to continue to [client A] when person in the steps and sat Came to about 45 of person, place a 3/11 with syncop this appeared to be just to continue to [client A] when person is stated to be supported to	at A's record was 12/12 at 2:55 P.M A's medical record dated 1/9/12: "Received shome (sic) staff Saturday at A] was coming down down and passed out. Seconds later was aware and time. Diagnosed be. Informed staff that be a syncope episode and to monitor and walk with possible."					
	_	dated 2/6/12: "Received on Sunday, 2/5/12 stating					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G190	B. WIN	IG		03/30/2012	
NAME OF I	PROVIDER OR SUPPLIE	R	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ENUE C		
ARC OF	ARC OF NORTHWEST INDIANA INC, THE			GRIFFI	TH, IN 46319		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
		as very weak and couldn't					
		e also lost control of her					
	bowels and blad	der at the table and didn't					
	even realize it.	I (Nurse) instructed staff					
	to have her trans	sported to the ER					
	(Emergency Ro	om) for evaluations and tx					
		mitted to hospital with					
		ract Infection) and blood					
	clot in left leg."	,					
	Nursing notation	n dated 2/13/12:					
	_	m the hospital on					
	_	2. Came back with a new					
	1	adin 5 mg (milligrams) qd					
	(everyday)."	aum 5 mg (mmgrums) qu					
	(cveryday).						
	Further review of	of the record indicated					
		eved to a different group					
		Ther discharge from the					
	-	/12 due to her not being					
	able to go up an	· ·					
	abic to go up an	u down stans.					
	Nursing notation	a dated 2/22/12:					
	_	from [Doctor's name]					
		bal order to hold					
		days and have blood					
		y due to high levels. Sent					
		use with instruction to					
		tion and sent the lab order					
		day when they have her					
	lab drawn."						
							ļ
	Nursing notation						
	"Received a call	from health tech stating					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		15G190	B. WIN	G		03/30/2012
NAME OF P	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					ENUE C	
ARC OF	NORTHWEST IND	IANA INC, THE		GRIFFI	TH, IN 46319	
(X4) ID				ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	that [client A] ha	•				
	•	she was breathing hard				
		s. Vitals were taken and				
		in normal limits). She				
		d normal now and that it				
	*	seconds. I instructed her				
		it again or if she had any				
	odd behavior."					
	Nursing notation	dated 2/23/12:				
	"Received a call	from North (workshop)				
	stating that there	was a small bruise on				
	[client A]'s head	that they don't believe				
	was there this me	orning."				
	Nursing notation	dated 2/23/12:				
	"Received call fr	om group home staff				
		t was not acting herself.				
	~	o answer questions when				
		Instructed staff to take				
		Il me backStaff returned				
		vithin normal limits, but				
		swering any questions				
		hat client eyes were				
		From side to side. I				
		o call 911. Client was				
		spital for evaluation and				
	treatment."	opiui ioi evaluation and				
	u caunciii.					
	Nursing notation	dated 2/23/12: "Client				
	passed away at h					
	passeu away at II	wspitai.				
	Nursing notation	dated 2/23/12: "Called				
	1	to let him know that the				
,		to let illili know that the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G190	B. WIN	G		03/30/2012
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			120 AV	ENUE C	
ARC OF NORTHWEST INDIANA INC, THE				GRIFFI	ΓH, IN 46319	
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
		ot held on 2/22/12He				
	` `	der) to hold it until after				
		rawn on Monday				
	2/27/12."					
	Further review o	f client A's record				
		th Risk Plan dated				
	11/3/11-Client ha					
		ealth Risk Plan dated				
	11/3/11-Client ha					
		Health Risk Plan dated				
	** *					
	11/3/11-Client ha	_				
	_	or bowel obstruction				
		hyroidismHealth Risk				
	1 ^	11-Client is at risk for				
		steadyHealth Risk Plan				
		t risk for impaired				
	circulation relate	ed to fractured clavicle."				
	A request for do	cumentation to show all				
	_	the group home were				
		A's "Health Risk Plans"				
		28/12 at 2:30 P.M The				
		ator and group home				
		al Nurse (LPN) did not				
	submit any docu					
	Saomit any docu	monution.				
	A request for do	cumentation to show all				
	_	the group home were				
		A's "Health Risk Plans"				
		29/12 at 3:00 P.M The				
		ator and group home LPN				
		ny documentation.				
	ara not buonnt ui					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15G190	B. WIN			03/30/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ENUE C		
ARC OF	NORTHWEST IND	IANA INC, THE			TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	A request for do	cumentation to show all					
	staff working at	the group home were					
	trained on client	A's "Health Risk Plans"					
	was made on 3/3	30/12. The Service					
	Coordinator and	group home LPN there					
		ntation to indicate all					
		f were trained on client					
	A's "Health Risk						
	713 Hourin Risk	Tiulis .					
	An interview wi	th Direct Support					
	`	SP) A was conducted on					
		P.M. DSP A indicated					
		ed any training on any of					
	client A's "Healt	h Risk Plans" or medical					
	concerns.						
		th DSP B was conducted					
	on 3/29/12 at 4:4	15 P.M DSP B					
	indicated she ne	ver received any training					
	on any of client	A's "Health Risk Plans"					
	or medical conce	erns.					
	A review of "De	ath					
	Investigation-Ad	lequete (sic) Care					
	Rendered #1686	7" was conducted on					
	3/30/12 at 12:07	P.M The record					
	indicated:						
	Interview with D	OSP A dated 2/24/12:					
	"[DSP A] came	off vacation on Monday					
		sumer was at the group					
		ot been trained on her					
		call for assistance from a					
	anterent staff on	a separate occasion of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G190	A. BUI	LDING	00	COMPLETED 03/30/2012
		130 190	B. WIN		DDDEGG GETY GT ATT TID GODE	03/30/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ENUE C	
ARC OF	NORTHWEST INDI	IANA INC, THE			TH, IN 46319	
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
TAG		on the floorstates she		TAU		DATE
	' '	Service Coordinator				
	_	l occasions to get training				
	_	her calls were not				
		ot see a risk plan in the				
		d see the MAR (Medical				
	Administration F	`				
	Interview with D	OSP B dated 2/24/12:				
		that she was not trained				
		are of the consumer				
		ic) not seen a risk plan at				
	the house, but the	•				
	Interview with da	ay program DSP E dated				
	2/24/12: "I work	xed with [client A]				
	Wednesday 2/22	/12I worked at the day				
	program yesterda	ay. I noticed while				
	working with her	r that her breathing has				
	always been shal	key to me and she was				
	thirsty all the tim	neNo I was not trained				
	to render care for	r [client A]."				
		y program DSP F datetd				
	2/24/12: "No tra	ining for her in				
	particular."					
	An interview wit	th the group home LPN				
		n 3/29/12 at 2:45 P.M				
		she did not have any				
		o indicate all group home				
		staff were trained on				
	1	al risk plans and medical				
	care needs.	p				

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	of correction identification number: 15G190	A. BUILDING B. WING	00	COMP. 03/30		
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
TAG	This federal tag relates to complaint #IN00104522. 9-3-6(a)	TAG	DEFICIENCY)	APPROPRIATE	DATE	

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	OF CORRECTION OF CORRECTION 15G190 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/30/2012
	136190	B. WING		03/30/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	120 AV	ADDRESS, CITY, STATE, ZIP CODE /ENUE C ITH, IN 46319	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W0368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W0368	See W 104 page 3, W 111 pa	age 04/29/2012
	Based on record review and interview, the facility failed to assure 1 of 1 discharged client (client A) received medications in compliance with the physician's orders.			
	Findings include:			
	A review of the client A's record was conducted on 3/22/12 at 2:55 P.M Review of client A's medical record indicated the following: Nursing notation dated 2/13/12:			
	"Discharged from the hospital on Saturday 2/11/12. Came back with a new order for Coumadin 5 mg (milligram) qd (). Will f/u (follow up) with [Doctor name] on 2/15/12."			
	Nursing notation dated 2/22/12: "Received a call from [Doctor's name] office with a verbal order to hold Coumadin for 3 days and have blood drawn on 4th day due to high levels. Sent memo to the house with instruction to hold the medication and sent the lab order to take on Saturday when they have her			

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	OF CORRECTION OF CORRECTION 15G190	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/30/2012		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION		
	lab drawn." Nursing notation dated 2/23/12: "Called [Doctor's name] to let him know that the Coumadin was not held on 2/22/12He stated (verbal order) to hold it until after she has her lab drawn on Monday 2/27/12." An interview with the group home Licensed Practical Nurse (LPN) was conducted at the facility's administrative office on 3/28/12 at 1:45 P.M The LPN indicated client A's Coumadin was not held as ordered by the physician. The LPN further indicated client A's Coumadin should have been held as ordered by the physician. This federal tag relates to complaint #IN00104522. 9-3-6(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G190	B. WIN	G		03/30/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ENUE C		
ARC OF	NORTHWEST INDI	ANA INC, THE		GRIFFI	TH, IN 46319		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W9999							
			W9	999	See W 104 page 3, W 111 pag 14, W 122	ge	04/29/2012
	State Findings:						
	The fellowing C	ammunity Dagidantial					
	_	ommunity Residential					
	Disabilities rule	sons with Developmental					
	Disabilities fule	was not met.					
	460 IAC 9-3-1(b)					
	The residential n	rovider shall report the					
	-	estances to the division					
	_	later than the first					
	business day foll						
	_	quested by the division.					
	summaries as rec	quested by the division.					
	This rule is not n	net as evidence by:					
	Based on record	review and interview, the					
		1 of 1 investigation					
	record reviewed						
		(client A), to report					
	_	opmental Disabilities					
) to report an injury of					
	· · · · · · · · · · · · · · · · · · ·	and a medication error in					
	a timely manner.						
	a uniciy mamier.	•					
	Findings include	:					
	A review of clier	nt A's record was					
	conducted on 3/2	22/12 at 2:55 P.M					
	Review of client	A's medical record					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G190	B. WING		03/30/2012
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	
ADC OF	NORTHWEST IND	IANA INC THE		VENUE C FITH, IN 46319	
				1111, 111 40519	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
TAG	l `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	
	indicated:				
	Nursing notation	dated 2/13/12:			
		n the hospital on			
	_	2. Came back with a new			
	order for Couma	din 5 mg (milligrams) qd			
	(everyday)."	- · · ·			
	Nursing notation	dated 2/22/12:			
		from [Doctor's name]			
	office with a ver				
		days and have blood			
		y due to high levels. Sent			
		se with instruction to			
		ion and sent the lab order			
		lay when they have her			
	lab drawn."				
		1.0.			
		th Direct Support			
	,	SP) B was conducted on P.M DSP B indicated			
		Coumadin was not held			
		o the group home staff			
		of the order and not			
		mo from the nursing staff			
	_	2/27/12. No BDDS report			
	was available for	-			
		vas available for review			
	to indicate the ac				
		ified of this incident.			
	Nursing notation	dated 2/23/12: "Called			
		to let him know that the			
	Coumadin was n	ot held on 2/22/12He			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		15G190	B. WIN	IG		03/30/2012	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					ENUE C		
ARC OF	ARC OF NORTHWEST INDIANA INC, THE			GRIFFI	TH, IN 46319		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5)	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
1710		der) to hold it until after		1110		DATE	
	,	rawn on Monday					
		DDS report was available					
		licate the facility reported					
	the incident.	meate the facility reported					
	and moracine.						
	An interview wi	th Direct Support					
		SP) A was conducted on					
	,	P.M. DSP A indicated					
		. Coumadin was not held					
	on 2/22/12 due to the group home staff not being informed to hold it before administering and further indicated the						
	_	not receive the memo					
		staff via e-mail until					
	_	DS report was available					
		licate the facility reported					
	the incident.	<i>y</i> 1					
	the includit.						
	A review of "De	ath					
	Investigation-Ac	lequete (sic) Care					
	Rendered #1686	7" was conducted on					
	3/30/12 at 12:07	P.M The record					
	indicated:						
	Interview with S	ervice Coordinator A					
		I got a phone call from					
		me] staff on 2/23/12					
		were trying to reach the					
		not get a hold of her, that					
		mer bleeding but not					
	_	of bleeding was indicated.					
	_	inator A name] told that					
	[group home nur	rse name] was at the					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING (00 COMPLET B. WING (03/30/20)				ETED		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319					
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE	
	office, they said I said I will have called [group hor office I told her a group home staff there. I did not he 6:30 P.M. on 2/2 from Area Mana home was trying consumer was go hospitalConsumer was available for facility reported Interview with de 2/24/12: "I work 2/23/12When so at 9:50 A.M. they I asked I needed and that her arm cleaned up and me BDDS report was indicate the facility Interview with de Safety Tech date on 2/23/12 by the the staff at the greer of or meds for be sure to make the brought her into	they could not reach her. her call you. Then I me nurse name] at the about the request from f and she needs to call hear anything else until 3/12 when I got a call ger. She said the group to reach me because bing to the mer was prescribed a vas moved temporarily to ne]." No BDDS report review to indicate the						

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED			
		15G190	B. WING 03/30/2012					
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
			120 AVENUE C					
ARC OF NORTHWEST INDIANA INC, THE				GRIFFI	TH, IN 46319			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE		
	the facility reported the incident.							
	l							
		th the group home						
		al Nurse (LPN) was						
		28/12 at 2:55 P.M The						
		ne did not assess client A						
		nt she was made aware						
		if client A was seen by a						
	1 ^ *	ne mentioned incidents,						
		No." When asked if the						
		A's arm bleeding on						
		umented and reported to						
		and BDDS, she stated						
	"No." When ask	ted if the medication error						
	was immediately	reported to the						
	administrator and	d BDDS, the LPN stated						
	"No."							
	An interview wa	s conducted with the						
	Service Coordina	ator (SC) at the facility's						
	administrative of	ffice on 3/28/12 at 2:20						
	P.M The SC in	dicated incidents are to						
	be reported within	in 24 hours to BDDS.						
		e documented incidents						
	was immediately	reported, the SC stated						
	"No."	•						
	A review of the l	Bureau of Developmental						
		ices (BDDS) reporting						
		March 1, 2011 was						
	1 -	26/12 at 7:00 P.M The						
		"It is the policy of the						
		y Improvement Services						
		an incident reporting						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G190		A. BUILDING	LE CONSTRUCTION 00	COM	E SURVEY PLETED 0/2012			
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			B. WING GS/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319					
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED 1	TO THE APPROPRIATE	(X5) COMPLETION DATE		
	tool in ensuring to the individuals readministered by reported to BQIS occurrence chara uncertainty result potential to result injury to an individual to result injury to an individual to: 2. Alleged, suspect (which must also be Protective Services, as indicated to: a. failure to provide care, or training; b. failure to provide environment; c. failure to provide services as needed d. failure to provide services as needed d. failure to provide safety equipment and individual Supportion 12. Any injury to a cause is unknown indicative of abuse 13. Any injury to a cause of the injury requires medical environment equires medical environments.	BDDSIncidents to be include any event or acterized by risk or ting in or having the tin significant harm or vidual including but not ted or actual neglect be reported to Adult is or Child Protective ated) which includes but is the appropriate supervision, the a safe, clean and sanitary the food and medical is the medical supplies or as identified in the						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
15G190		15G190	B. WING 03/30/			/2012	
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
					ENUE C		
ARC OF	ARC OF NORTHWEST INDIANA INC, THE			GRIFFITH, IN 46319			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR		TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	a. wrong medicati	on given;					
	b. wrong medicati	on dosage given;					
	c. missed medicat						
	d. medication give						
	e. medication						
	c. incurcation						
	Responsible Part	ios					
	_	sponsible for an individual					
	_	*					
		occurrence of a reportable					
		nit an incident initial					
	report.						
	2. In addition to the provider 's mandatory						
		er person may submit an					
	_	ort associated with any					
	reportable inciden	t.					
	3. The entity respo	onsible for incident					
	follow-up reports	is the individual 's:					
	a. case manager, v	when receiving waiver					
	funded services;	_					
	b. residential prov	ider ' s Oualified					
		isabilities Professional					
	1 -	eiving State Line Item					
		Group Living (SGL), or					
	other ICF/MR ser						
		then receiving Caregiver					
	Supports Services						
		coordinator when receiving					
		. Title XX and nursing					
	facilities).						
	Initial incident re	= -					
		s of initial discovery of a					
	1 -	t, the reporting person shall					
	file an incident ini	tial report with BQIS using					
	the DDRS approv	ed electronic format					
	available at						
		er.fssa.in.gov/IFUR/. In the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		15G190	B. WIN		03/30/2012		
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
WHILE OF THE VIDER OR SOFTELER				120 AV	ENUE C		
ARC OF NORTHWEST INDIANA INC, THE				GRIFFI [*]	TH, IN 46319		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE	
		malfunction, incident					
	_	incident follow-up reports					
	may be e-mailed t						
	to 260-482-3507.	ports@fssa.in.gov, or faxed					
		erson shall be descriptive					
		the narrative portions of the					
		ort form, including:					
	_	e description of the					
	incident;	o accomption of the					
	· · · · · · · · · · · · · · · · · · ·	the circumstances and					
	activities occurring immediately prior to the incident; c. a description of any injuries sustained						
	during the inciden	•					
		both the immediate actions					
	_	en, and actions that are					
	planned but not ye	et implemented; and					
	e. a listing of each	person (first name, last					
	initial) involved ir	the incident, with a					
	description of the	role and staff title, if					
	applicable, of each	_					
		of this policy contains					
	additional directiv	· •					
	1 *	d objective information on					
	the incident initial	report.					
	Reportable Incid	ent Follow-Up					
	_	y be closed by BQIS upon					
	receipt and proces	sing.					
		not closed upon BQIS'					
	receipt and proces	sing, BQIS shall forward					
	an email notificati	on to the person					
	responsible for inc	cident follow-up reporting.					
	3. The person resp	oonsible for incident					
	follow-up reporting	_					
	a. submit an electr	onic incident follow-up					

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i i		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 03/30/2012				
		15G190	B. WIN			03/30/	2012
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE ENUE C		
ARC OF	NORTHWEST IND	IANA INC, THE			TH, IN 46319		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	(EACH DEFICIENCY MUST BE PERCEDED BY FULL				CROSS-REFERENCED TO THE APPROPRIATE		
PREFIX TAG	report within 7 da incident initial rep b. continue to sub reports on an ever time as the incident satisfaction of all c. forward copies the same entities wincident initial rep 4. Exhibit "B" additional directive comprehensive and the incident follow. An interview will Licensed Practice conducted on 3/2 LPN indicated slafter each incident of. When asked physician after the LPN stated "incident of client 2/23/12 was doce the administrator "No." When ask was immediately	ys of the date of the cort; mit incident follow-up y 7 day schedule, until such at is resolved to the entities; of each follow-up report to who received a copy of the cort. Of this policy contains res for providing dobjective information on v-up report. th the group home al Nurse (LPN) was 28/12 at 2:55 P.M The he did not assess client A ant she was made aware if client A was seen by a me mentioned incidents, No." When asked if the ta's arm bleeding on umented and reported to read BDDS, she stated ared if the medication error		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION DATE
	9-3-1(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FUPR11

Facility ID: 000722

If continuation sheet

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